

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

MAY 30, 1997 STUDY SESSION NOTES

Friday, May 30, 1997 - 2pm-4:30pm
Greater San Diego Chamber of Commerce
402 W. Broadway, 10th Floor
San Diego, California

I. CALL TO ORDER [Chairman Alain Enthoven, Ph.D.] - 2:00 P.M.

The first study session of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Greater San Diego Chamber of Commerce in San Diego, California.

II. ROLL CALL

Task Force Secretary, Ms. Jill McLaughlin, took roll. The following Task Force members declared they were present: Dr. Bernard Alpert, Mr. Rodney Armstead, Dr. Donna Conom, Dr. Alain Enthoven, Ms. Jeanne Finberg, Dr. Bradley Gilbert, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Ms. Kathryn Murrell, Dr. J.D. Northway, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, and Mr. Ronald Williams.

The following ex-officio members were also present: Ms. Kim Belshe, Mr. Keith Bishop, and Mr. Michael Shapiro.

III. OPENING REMARKS

Chairman Enthoven announced that the focus of today's study session would be the roles, functions and organization of state government in regulating health care service plans. More specifically, to define what role government plays in regulating managed care, where its regulatory functions repose, how government exercises its regulating authority, and how efficient and effective is the regulatory function. Chairman Enthoven also announced that the last sixty minutes of today's session would be allocated to discuss the Task Force work plan schedule.

IV. REPORTS

A. The role of government and the organization of government's regulation of managed care [Ms. Hattie Skubik, Deputy Director for Policy and Research, Managed Health Care Improvement Task Force, and Mr. Elias Lopez, Ph.D., Economist/Demographer, California Research Bureau].

Deputy Director Skubik began the study session by distributing a handout that described the regulatory role of state government. Deputy Director Skubik described the spectrum of choice that consumers have regarding health care, ranging from closed panel HMOs to fee-for-service (FFS) health plans. HMOs are overseen by the Department of Corporations (DOC) while FFS plans are overseen by the Department of Insurance (DOI). She noted that the health care market is integrating

vertically to include financing and delivery. Deputy Director Skubik also indicated the need to look at critical state government oversight functions, particularly the consumer grievance process.

Dr. Lopez distributed additional handouts and continued the discussion on state regulatory functions, focusing on the consumer grievance process. He described the three steps of the common grievance process. First, the consumer/patient registers a complaint with the health plan. Second, if the complaint isn't resolved at that level, the consumer can call a state "1-800" hotline number. Third, the relevant state agency makes a decision about the complaint.

Dr. Lopez outlined more details of each agency's (DOC, DOI, and DHS) grievance process. He noted that both DOI and DOC require a written complaint, while DHS is able to take complaints by phone because they have Medi-Cal patient files on-line. He also noted that under DOC rules, the consumer must file their complaint with the health plan and allow the health plan 60 days to respond before the consumer can file a complaint with DOC. DHS requires a 30 day response period. DOI does not have a specific requirement. Dr. Lopez stated that the grievance process is not very consumer oriented because consumers can be "bounced around" from agency to agency. Task Force members discussed the possibility of establishing a single phone number that consumers could call to be referred to the proper oversight agency.

Mr. Lee pointed out that most complaints are resolved with the individual provider. He stated that some plans will not take a consumer's complaint until the consumer tries to resolve the complaint at the medical group level. He also noted several other sources of assistance, including the employer, group purchaser, insurance broker, or Medicare-specific groups. Mr. Lee also pointed out that complaints against self-insured plans are handled by the federal Department of Labor. Mr. Bishop later added that some complaints are handled by more than one agency at a time, and that arbitration or lawsuits might also be pursued simultaneously.

Mr. Shapiro commented on budget reductions that the Department of Insurance underwent and how these cuts have affected the efficiency of its consumer services division. As a result of these cuts, the DOI started to require consumers who called the consumer's hotline to submit a written request for assistance. If consumers did not follow through on that written request, they did not get the help that they might have needed. This procedure had a significant attrition rate which allowed DOI to become more efficient but at an expense.

Dr. Karpf then shifted the discussion towards the issue of complaints. He said that it is not only important to receive complaints but also to study any possible patterns and systemic issues that can be identified through the complaints.

Mr. Bishop, responding to the comment, said that DOC produces such complaint reports. He indicated that the report divides the complaints up into 32 different categories and lists by both full-service and specialized plans the number of complaints per 10,000 enrollees. He stated that many health plans are required to file reports on a quarterly basis regarding complaints that have been pending longer than 30 days. Those reports are filed with the department and are publicly available. Dr. Karpf then asked whether DOI and DHS had similar reports available.

Dr. Rodriguez-Trias asked Mr. Bishop to elaborate on the enforcement mechanism of DOC's oversight. Mr. Bishop said that enforcement action can happen in two ways. It may be dealt with administratively. That is, an order to cease and desist may be issued and/or a fine may be levied. Or

it may be dealt with civilly. In this case a wide variety of remedies may occur such as fines, appointments of receivers, appointments of monitors, et cetera. He stated that the Knox-Keene act gives DOC a lot of different enforcement tools, but that the focus tends to be on fines. Mr. Bishop then discussed due process. He stated that DOC's grievance process does not afford all due process rights to either the person making the complaint or the plan.

Dr. Alpert stated that Task Force recommendations on this topic should focus on making sure that the regulating agency is staffed with people who have expertise "across the board" in financial and health-related aspects. Mr. Bishop stated that there are three types of professionals who work for the DOC: lawyers, health analysts, and financial examiners.

Dr. Spurlock commented on one of the possible causes of consumer dissatisfaction. He said that many consumers' complaints are a function of the relationship and the communication between consumers and health providers and not a function of the care. Dr. Karpf added that many consumers' complaints arise from the disconnection between the levels of expectations and what is in fact available and appropriate. Mr. Williams stated that consumers feel that no matter where in the system the problem occurs, the health plan is responsible.

Ms. Finberg asked whether or not medical groups are regulated. Mr. Bishop stated that some large medical groups have limited Knox-Keene licenses and are directly regulated. He said that the other medical groups are indirectly regulated through plans that are held accountable and responsible for delivering services in compliance with the Knox-Keene Act.

Mr. Lee stated that there will always be some complaints and that the ultimate goal is to create health care systems that will minimize the need for sophisticated grievance processes. Good health plans resolve their complaints effectively and quickly so they rarely get to the regulatory point. Pointing out the lack of information that many consumers have about their health plans, Mr. Lee also said that an effective system is one that informs its customers about their coverage, their rights, and how to exercise them.

Agreeing with Mr. Lee, Dr. Rodriguez-Trias noted that complaints are indeed the tip of the iceberg. Complaints, many times, relate to human relations. Thus a health plan with very good public relations tends to receive low numbers of complaints. However, high or low numbers of consumer complaints are not indicators of quality care. That is, health plans may have very good public relations, but the quality of their health services may be very poor.

Mr. Williams outlined appropriate roles for government in the regulation of health care, including ensuring consumer protection; product adequacy; financial solvency at the health plan and medical group levels; a competitive marketplace; and expanding coverage as far as possible.

Ms. Belshé encouraged the Task Force to systematically identify the most problematic concerns in the current system and determine who has responsibility for addressing those problems: the private sector, government, or a partnership. She also encouraged the Task Force to think about how government should be organized to meet its responsibilities and form partnerships with the private sector.

Break

Public Comment

- 1) Dr. Schumacher, former president of the Medical Board of California** Dr. Schumacher stated that the Medical Board was only mentioned briefly in the earlier discussion, yet it is the main avenue in California for resolution of grievances concerning the quality of care. He also mentioned the role of county medical societies. He offered some reports and testimony on quality of care and the physician-patient relationship.

Dr. Schumacher also made some comments on regulation. He argued that the regulatory system is very fragmented. He stated that there is almost no regulation of medical groups. He concluded that there are two departments that currently have the expertise to deal with quality of care issues: the Medical Board and other associated departments in the Department of Consumer Affairs, and DHS. He stated that DOC and DOI do not have the required expertise to regulate the rapidly-changing managed care system.

- 2) Dr. Robert C. Fellmeth, Director of the Center of Public Interest Law** Dr. Fellmeth recommended that the Task Force avoid regulatory structures such as DOI, which he described as a single entity looking at thousands of consumer complaints without ever disciplining anybody. He recommended instead a board structure with the opportunity for public input and with representatives who are knowledgeable about quality of care.

Moreover, Dr. Fellmeth suggested that consumer grievances should be handled by the Office of Administrative Hearings (within the Department of General Services). OAH has a panel of administrative law judges to address medical matters.

B. The Scope Of Work To Be Performed By The Task Force And Task Force Staff.

Chairman Enthoven introduced the concept of “expert resource groups” - small working groups on particular topics, composed of one or two Task Force members. Deputy Director Skubik asked if it would be possible to include particular experts who are not necessarily members of the Task Force but who have high levels of expertise on a particular matter.

Executive Director Romero then discussed possible topics for future Task Force meetings. He mentioned six topics (consumer protection, regulatory organization, quality of care, increasing choice among plans, increasing choice within plans, and industry restructuring) and asked the Task Force for their additions and priorities.

Mr. Williams stated that the Task Force should be sensitive to the fact that some reforms might lead to the unintended consequence of increasing the number of uninsured. Dr. Rodriguez-Trias said that the Task Force should take a more proactive stance and focus on increasing the effectiveness of managed care by increasing coverage. She suggested the Task Force discuss means of enhancing the ability of small businesses and employers to purchase insurance for their employees. Mr. Shapiro cautioned the Task Force against worrying about covering the uninsured at the expense of creating a second-class medical system. He stated that other groups were working on that issue.

Ms. Severoni suggested the Task Force consider the topic of consumer involvement. Mr. Lee asked that the topics of managed care’s impact on vulnerable populations, managed care’s impact on the physician-patient relationship, and improving information about quality be included.

Finally, through an informal poll of the members where each member could voice two preferences, Executive Director Romero prioritized future items of discussion. The priorities were quality of care (13 members), enhancing consumer protection (8 members), addressing the regulatory structure (3 members), increasing choice among plans (3 members), restructuring the health care industry (1 member), and increasing choice within plans (0 members). Ms. Alice Singh stated that absent members would also have an opportunity to voice their preferences through an anonymous Delphi questionnaire.

It was then agreed that staff would try to obtain some materials on what other states are doing with regards to managed care (e.g., Minnesota and Washington state).

V. ADJOURNMENT - 5:00 P.M.

Chairman Enthoven said that without objection, the study session would be adjourned. Hearing and seeing no objection, Chairman Enthoven declared the Study Session adjourned and announced that a public hearing would commence in the City of San Diego Council Chambers in 15 minutes.

Prepared by: Enrique J. Ramirez, Ph.D.